**Testimony**
**Health and Human Services Committee**
**Thursday, October 7, 2010**
**North Dakota Department of Health**

Good afternoon, Chairman Weisz and members of the Health and Human Services Committee. My name is Arvy Smith, and I am the Deputy State Health Officer for the North Dakota Department of Health. I am here today to provide information regarding the universal option for providing immunization services in North Dakota.

As indicated, the consultant, Mr. Nye, has made some recommendations regarding the purchase of vaccines through the Universal Vaccine Supply Policy. There are significant financial and administrative reasons to consider this, as well as the ability to provide all immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) to all children at all places. This option affects only the insured or non-VFC children. (Vaccines for Children are provided by the federal government for all Medicaid, uninsured, underinsured, Native American and Alaska Native children.) VFC procedures would remain as they are today.

Assuming we would provide the same numbers of vaccines as in fiscal year 2010, it would cost $7.8 million per year to vaccinate the same children at the federal contract rates and $10.3 million at private purchasing rates. This is a difference to insurers of $2.5 million per year. Said another way, the cost to vaccinate one child through 18 years of age is $1,707 at the federal contract rates versus $2,249 at the private rates, a difference of $542 or 24 percent per child. However, we know that some of the private providers were able to get reduced private rates through bulk purchasing of medical supplies, bringing their cost for the vaccine down below the stated private rates. In some cases, the provider billed insurance at the reduced rate; this would reduce the amount of projected savings to $1.5 to $1.8 million per year. In other cases, the provider billed insurance at the higher rate, making a profit on the vaccine; moving to universal would result in loss of this revenue to those providers. In addition, if the volume of vaccine purchases increased the providers' savings on other medical supplies purchased, these savings could be lost to the providers.

The administrative savings to providers are achieved through reduced efforts required to manage vaccine inventories. Once a state chooses to be universal, which means providing all ACIP-recommended vaccinations, the federal government estimates the amount of VFC vaccine, and as long as the state

covers the rest of the population, vaccine inventories do not need to be stored and tracked separately. This saves a great deal of administrative time for providers. The drawback is that the providers who serve out-of-state children will need to purchase and separately track out-of-state non-VFC vaccines.

Another disadvantage to purchasing off the federal contract is that providers may order at a maximum of only once per month, depending on the size of the provider. Some providers are accustomed to ordering as frequently as weekly. Limited ordering will require them to store larger amounts of inventory to ensure that they have an adequate supply and do not run short of vaccine, losing opportunities to vaccinate children.

Since we found out that the state could purchase off of the federal contract rates, we have been working to identify and validate the perceived barriers, determine the extent of the impact of a barrier and seek solutions to those barriers by making contact with the groups impacted.

We have discussed this with local public health units, and they have voted to support moving to universal vaccination. The local public health units report that it will be much easier to conduct mass vaccination clinics, including school clinics, under a Universal Vaccine Supply Policy because they won't have to screen children up front as to their VFC status or have to manage private and public supplies of vaccine separately. We have contacted several of the private provider groups, explained some of the disadvantages of universal vaccination to them and probed for other disadvantages. So far, the private providers have ranged from wholeheartedly supporting universal to recognizing that even considering the disadvantages, universal was probably the right thing to do. We also are visiting with Blue Cross Blue Shield, and they are considering the ramifications to them. They recognize there will be financial savings but there are some issues to work out yet. Next, we visited with representatives from a pharmacy company, who indicated that their preference is to leave this to the private market but that they understand why people would want to make the change. They communicated some preferences they would like to see if we choose to move forward with universal vaccination. Finally, we are reviewing how other states have set up universal vaccination.

We are carefully considering all options for immunization services. One obstacle is that the success of universal vaccination and purchasing off the federal contract is based on the assumption that all insurance companies are required to fully cover all ACIP-recommended vaccines for children. Current health-care reform language requires this but allows plans to be grandfathered

in under certain circumstances until 2014, at which time preventive services will be evaluated and requirements finalized. So there will be some insurance plans that still have copayments and deductibles applicable to vaccines. We are evaluating the extent to which this might occur and how this could be addressed.

One of our greatest concerns is that we provide a system that is sustainable into the future. It is important to recognize that there will likely be new vaccines in the future that will be recommended by the ACIP. While these vaccines will prevent disease and may reduce costs later on, there will be a cost to these vaccines. If health reform legislation continues to require insurers to cover all ACIP-recommended vaccines, insurers and payers will not have the option to exempt the new vaccines, and it will be less costly to purchase them at the federal contract rates rather than at private rates.

In North Dakota, more than 100 insurers provide vaccine coverage for 104,000 children who receive almost 200,000 vaccines at around 280 provider sites each year. There are still several issues to address if a universal vaccination system were established in North Dakota. We hope to offer the 2011 Legislative Assembly additional information to develop a plan for vaccinating children in North Dakota that is fair, sustainable and cost effective and that assures that every child can be provided all ACIP-recommended vaccines.

This concludes my testimony. We look forward to input from this committee on this important program. I would be happy to answer any questions that you may have.